

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **44431**
11925BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN **St Louis**c. LENGTH OF STAY (in this place) **25 Days**d. FULL NAME OF HOSPITAL OR INSTITUTION **City Hospital**

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

a. STATE **Missouri**b. COUNTY **W**c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN **St Louis**d. STREET ADDRESS (If rural, give location) **23 309a Lafayette****2289**

3. NAME OF DECEASED

(Type or Print)

a. (First)

b. (Middle)

c. (Last)

4. DATE OF DEATH

(Month) **Dec**

(Day)

(Year) **1953****Marcha****Portell**

5. SEX

female

6. COLOR OR RACE

white7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **never married**

8. DATE OF BIRTH

Nov-22-1953

9. AGE (In years last birthday)

if under 1 year

Months

Days

if under 1 wk.

Hours

Mins.

25**1****U.S.A.**

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

none

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and State or Foreign Country)

St Louis, Mo

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13a. FATHER'S NAME

Andrew Portell

13b. MOTHER'S MAIDEN NAME

Easter Sansoucie

14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

none

17. INFORMANT'S SIGNATURE OR NAME

Mrs Easter Portell 396a Louis, Mo

ADDRESS

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)

MEDICAL CERTIFICATION

Atelectasis of lung

INTERVAL BETWEEN ONSET AND DEATH

25 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) **Congenital**

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS*

Conditions contributing to the death but not related to the disease or condition causing death.

Enlarged heart

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP)

(COUNTY)

(STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR?

762022. I hereby certify that I attended the deceased from **11-22-53, 19**, to **12-17-53, 19**, that I last saw the deceased alive on **12-17-53, 19**, and that death occurred at **4:20P m.**, from the causes and on the date stated above.

23a. SIGNATURE

(Degree or title)

23b. ADDRESS

23c. DATE SIGNED

Elizabeth K. Gay M.D.**1515 Lafayette Avenue****12-18-53**

24a. BURIAL, CREMATION, REMOVAL (Specify)

24b. DATE

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town, or county)

(State)

Burial**12-19-1953****St Joseph cemetery****Tiff, Mo**

DATE REC'D BY LOCAL REG.

DEC 18 1953

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Potosi, Mo**Carl Smith M.D.****Arthur W. Smith**

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Mary M. Smith

Licensed Embalmer No. 4394

P. O. Address Potosi, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.